Admit a Patient

Introduction

If you make a change to the room/bed, you will be asked if you would like to notify Building Management of the vacated bed. A YES response at this prompt will generate a MailMan bulletin to all members assigned to the DG BLDG MANAGE-MENT mail group. If no members have been assigned to this mail group, no message will be sent.

Utilizing this option may cause a MailMan bulletin to be sent to appropriate hospital personnel alerting them of the patient's insurance coverage. The bulletin, UR ADMISSION BULLETIN, will only be sent if members have been assigned to the DGPM UR ADMISSION mail group and the selected patient has at least one active insurance policy on the date of admission.

The FUTURE ACTIVITY SCHEDULED bulletin is sent when veterans with verified eligibility and either scheduled admissions or waiting list entries are admitted. It contains a list of all scheduled admissions and waiting list entries on file for the patient and is sent to the mail group users designated in the UNVERIFIED ADMIT GROUP field of the MAS PARAMETERS file. If the patient is a non-veteran, this information will be included in the NON-VETERAN ADMISSION bulletin. If the patient's eligibility is not verified, this information will be included in the VETERAN ADMISSION WITHOUT VERIFIED ELIGIBILITY bulletin.

An ADMISSION OE/RR NOTIFICATION may be displayed with V. 2.2 or higher of Order Entry/Results Reporting. The notification will only be displayed for patients who are defined in an OE/RR LIST entry and will only be displayed to users defined in that list entry. Please refer to the Order Entry/Results Reporting documentation for more information concerning OE/RR notifications, if needed.

If the Primary Care Management Module (PCMM) is loaded, a MailMan message will be sent to the patient's primary care team members who chose to receive inpatient notifications when the patient is admitted.

If the patient has dual eligibility, you will be asked for the eligibility associated with the admission.

If the selected admitting regulation has subcategories, you will be asked to select the appropriate subcategory.

Admit a Patient

Example

Admit PATIENT: **MCKEE,SCOTT**   03-16-70   705031670   YES   SC VETERAN

Means Test not required based on available information

Primary Care Team: BLUE   Team Phone: 555

Status   : INACTIVE INPATIENT   Discharge Type : REGULAR

Admitted   : MAY 10,1996@14:35:03   Discharged   : MAY 12,1996@11:02:29
Ward   : 8B   Room-Bed   : 801B-2
Provider   : JONES,MARTIN   Specialty   : MEDICINE
Attending   : KIRBY,KENT

Religion   : CATHOLIC   Marital Status : DIVORCED
Eligibility : SC 50% TO 100% (VERIFIED)

Admission LOS: 3 Absence days: 0 Pass Days: 0 ASIH days: 0

<C>ontinue, <M>ore, or <Q>uit? CONTINUE//   **MORE**

  Active clinic enrollments:
     SURGICAL, MEDICAL

  Future Clinic Appointments:
     Patient has no future appointments scheduled

CHOOSE FROM:
 1> MAY 10,1996@14:35:03 DIRECT   TO: 8B [803-B]
 2> APR 16,1996@10:20:06 DIRECT   TO: 8B [801-B]

Select ADMISSION DATE: NOW// **<RET>** (MAY 23,1996@11:07:28)
SURE YOU WANT TO ADD 'MAY 23,1996@11:07:28' AS A NEW ADMISSION DATE? //   **Y**
(Yes)
ADMITTING REGULATION: **SHARING AGREEMENT**   17.46(d)
THE [SHARING AGREEMENT] ADMITTING REGULATION
HAS THE FOLLOWING SUB-CATEGORIES DEFINED.
     FBI
     DOD
ENTER THE SUB-CAT FOR THE [SHARING AGREEMENT] ADMITTING REG: FBI//   **DOD**
ADMITTED FOR SC CONDITION?: YES//   **<RET>**   YES
TYPE OF ADMISSION: **DIRECT**   ADMISSION   ACTIVE
DIAGNOSIS [SHORT]: **ANGINA**
WARD LOCATION: **8B**
ROOM-BED: **801B-2**
FACILITY TREATING SPECIALTY: **MEDICINE**
PRIMARY CARE PHYSICIAN: **JONES,MARTIN**
ATTENDING PHYSICIAN: **KIRBY,KENT**
DIAGNOSIS:
  1>ANGINA
EDIT Option: **<RET>**

Admit a Patient

Example

```
SOURCE OF ADMISSION:  1M   OTHER DIRECT      HOSPITAL
THIS PATIENT HAS OTHER ENTITLED ELIGIBILITIES:
     SC
     TRICARE/CHAMPUS
ENTER THE ELIGIBILITY FOR THIS ADMISSION: SC//   <RET>
Patient Admitted
Do you want to print a Patient Wristband? YES//   <RET>
PRINT WRISTBAND ON DEVICE:  P-BARCODE BLAZER
DO YOU WANT YOUR OUTPUT QUEUED? NO//  <RET>

Updating PTF Record #2626...
Now updating ward CDR information...completed.
Executing HL7 ADT Messaging

Updating incomplete records...

Updating claims tracking

Capturing Event Driven Reporting workload...completed.
Sending INPATIENT ADMISSION Message..........
```

Example of primary care mail bulletin.

```
Subj: INPATIENT ADMISSION for MCKEE,SCOTT(705-03-1670)  [#36272]
13 May 96 11:29  12 Lines
From: STELLA,KAREN H  in 'IN' basket.   Page 1
-----------------------------------------------------------------------------

Patient:                MCKEE,SCOTT(705-03-1670)
Transaction:            ADMISSION
Date/Time: MAY 23,1996@11:07:28
Type of Movement:       DIRECT

Ward Location:          8B
Room-Bed:               801B-2
Inpatient Provider:
Admitting DX:           ANGINA

Current Primary Care Management Data:
  PC Team:              BLUE


Select MESSAGE Action: IGNORE (in IN   basket)//
```

Means Test User Menu
Edit an Existing Means Test

Introduction

The Edit an Existing Means Test option is used to make changes to data in existing Means Tests. It may also be used to complete Means Tests on patients identified through Registration as requiring Means Testing. Only the latest Means Test may be edited. A Means Test that has been verified by the Income Verification Match (IVM) Center and its corresponding original VAMC Means Test are both uneditable. If you choose such a Means Test, the system will display a message containing this information. However, this option will let you view or print such a test.

The Edit an Existing Means Test option operates similarly to the Add a New Means Test and Complete a Required Means Test options; however, it is the only option which allows changes to completed Means Tests. After these changes are entered, the system redetermines the patient's Means Test category and changes it, if necessary. If additional information is needed to make a determination or if it is necessary to refer the case to adjudication, the system prompts accordingly.

The date(s) and name(s) of individual(s) making changes is recorded by the system and may be seen through the View Means Test Editing Activity option.

A Means Test is required under the following conditions.

- primary eligibility is NSC or 0% service-connected non-compensable
- does not receive disability retirement from the military
- is not eligible for Medicaid
- is not on a domiciliary ward
- has not been Means Tested in the past year

Should these criteria change (excluding the last two), a Means Test status of NO LONGER REQUIRED will be assigned to the Means Test. Tests with this status cannot be edited.

Depending on the information entered on Screen 1, Screen 2 may appear with one column - veteran; two columns - veteran/spouse; or three columns - veteran/spouse/dependents. The item number(s) you select for editing may be preceded by V (veteran), S (spouse), or C (children) to select those specific fields; otherwise, the fields for all three will be displayed.

Census Menu
Load/Edit PTF Data

Example
The user chooses not to edit the "101" screen.


```
Select PTF PATIENT:  B4588   BROWN,KENNETH   Admitted: 02-11-88   Open   01-17-
21   258904588   SC VETERAN

Updating PTF record #545
Now updating ward CDR information...completed.

Name: BROWN,KENNETH  SSN: 258904588  Dt of Adm: FEB 11,1988 09:22  <101>

[1]    Facility: 509                    [2]   Marit Stat: MARRIED
   Source of  Adm: OUTPATIENT TREATMENT          Race: WHITE,NOT OF HISPAN
   Source of Pay:                                 Sex: MALE
 Trans Facility:                        Date of Birth: JAN 17,1921
     Admit  Elig: SC LESS THAN 50%              SCI: NOT APPLICABLE
[3] Vietnam SRV: NO                      [4] State: MONTANA
            POW: NO                          Zip Code: 44444
         POW SRV:                              County: LEWIS AND CLARK
    Ion Rad Exp: YES
    Agent Or Exp: NO

[5] Date of  Disch: APR 29,1991 15:10     Disch Specialty: CARDIOLOGY
    Type of  Disch: REGULAR                 Disch Status: BED OCCUPANT
    Place of Disp: RET TO COMMUN-I        [6] Out Treat: YES
       Means Test: SERVICE CONNECTED         VA Auspices: YES
[7]   Receiv facil:                       [Other Fields]
       C&P Status: COMP/SC COND>l0%             Income: $13000
         ASIH Days:                      SC Percentage: 30
                                        Period of    Serv: KOREAN


Enter:  <RET> for <MAS>,
1-7 to edit, '^N' for screen N, or '^' to abort: <MAS>//    <RET>
```

Census Menu
Load/Edit PTF Data

Supplement

This supplement is included to give a further explanation of the fields (data items) that constitute the Patient Treatment File. This section lists some of the data items that can be edited through the different PTF screens and a brief description of each item. Examples of the "CDR" screen and description of the data elements contained on it are provided at the end of the Supplement.

SCREEN	FIELD NAME OR PROMPT	DESCRIPTION
"101"	FACILITY	Facility number where patient was admitted
	SUFFIX	Suffix of admitting facility
	SOURCE OF ADMISSION	Source of this patient admission; from SOURCE OF ADMISSION file
	SOURCE OF PAYMENT	For patients treated at non-VA hospitals at VA expense; from set of codes
	TRANSFERRING FACILITY	VA facility from which the patient was transferred
	TRANSFERRING SUFFIX	Suffix of transferring facility
	CATEGORY OF BENEFICIARY	Code that indicates the patient's military status from CATEGORY OF BENEFICIARY file
	ENTER THE ELIGIBILITY FOR THIS ADMISSION	For patients with dual eligibility, the eligibility associated with the admission
	MARITAL STATUS	Patient's marital status
	RACE	Patient's race
	SEX	Patient's sex
	SPINAL CORD INJURY	Code that indicates if this patient sustained a spinal cord injury and, if so, what type
	DATE OF BIRTH	Patient's date of birth
	VIETNAM SERVICE INDICATED	YES/NO - Did patient serve in Viet Nam?

Load/Edit PTF Data

Example

The user chooses to edit items in group 6.

```
Select PTF PATIENT:  B4588   BROWN,KENNETH   Admitted: 02-11-96   Open   01-17-
21   258904588   SC VETERAN

Updating PTF record #545


Name: BROWN,KENNETH  SSN: 258904588 Dt of Adm: FEB 11,1996 09:22  <101>


[1]    Facility: 509                 [2] Marit Stat: MARRIED
   Source of Adm: OUTPATIENT TREATMENT          Race: WHITE,NOT OF HISPAN
   Source of Pay:                               Sex: MALE
 Trans Facility:                      Date of Birth: JAN 17,1921
     Admit Elig: SC LESS THAN 50%               SCI: NOT APPLICABLE
[3] Vietnam SRV: NO                   [4] State: MONTANA
            POW: NO                       Zip Code: 44444
        POW SRV:                            County: LEWIS AND CLARK
    Ion Rad Exp: YES
    Agent Or Exp: NO

[5] Date of Disch: APR 29,1996 15:10   Disch Specialty: CARDIOLOGY
     Type of Disch: REGULAR              Disch Status: BED OCCUPANT
     Place of Disp: RET TO COMMUN-I    [6] Out Treat: NO
        Means Test: SERVICE CONNECTED     VA Auspices: NO
[7]   Receiv facil:                    [Other Fields]
        C&P Status: COMP/SC COND>l0%            Income: $13000
         ASIH Days:                     SC Percentage: 30
                                      Period of Serv: KOREAN


Enter:  <RET> for <MAS>,
1-7 to edit, '^N' for screen N, or '^' to abort: <MAS>//    6


OUTPATIENT TREATMENT: NO//  YES
VA AUSPICES: NO//  YES
```

Load/Edit PTF Data

Example

The "101" screen is redisplayed with the new values.

```
Name: BROWN,KENNETH  SSN: 258904588 Dt of Adm: FEB 11,1996 09:22  <101>

[1]    Facility: 509                 [2] Marit Stat: MARRIED
  Source of Adm: OUTPATIENT TREATMENT         Race: WHITE,NOT OF HISPAN
  Source of Pay:                               Sex: MALE
 Trans Facility:                     Date of Birth: JAN 17,1921
     Admit Elig: SC LESS THAN 50%              SCI: NOT APPLICABLE
[3] Vietnam SRV: NO                  [4] State: MONTANA
            POW: NO                    Zip Code: 44444
        POW SRV:                         County: LEWIS AND CLARK
    Ion Rad Exp: YES
   Agent Or Exp: NO

[5] Date of Disch: APR 29,1996 15:10  Disch Specialty: CARDIOLOGY
     Type of Disch: REGULAR             Disch Status: BED OCCUPANT
     Place of Disp: RET TO COMMUN-I   [6] Out Treat: YES
        Means Test: SERVICE CONNECTED    VA Auspices: YES
[7]   Receiv facil:                  [Other Fields]
       C&P Status: COMP/SC COND>l0%          Income: $13000
        ASIH Days:                    SC Percentage: 30
                                     Period of Serv: KOREAN


Enter:  <RET> for <MAS>,
1-7 to edit, '^N' for screen N, or '^' to abort: <MAS>//    <RET>
```

Load/Edit PTF Data

Supplement

This supplement is included to give a further explanation of the fields (data items) that constitute the Patient Treatment File. This section lists some of the data items that can be edited through the different PTF screens and a brief description of each item. Examples of the "CDR" screen and description of the data elements contained on it are provided at the end of the Supplement.

SCREEN	FIELD NAME OR PROMPT	DESCRIPTION
"101"	FACILITY	Facility number where patient was admitted
	SUFFIX	Suffix of admitting facility
	SOURCE OF ADMISSION	Source of this patient admission; from SOURCE OF ADMISSION file
	SOURCE OF PAYMENT	For patients treated at non-VA hospitals at VA expense; from set of codes
	TRANSFERRING FACILITY	VA facility from which the patient was transferred
	TRANSFERRING SUFFIX	Suffix of transferring facility
	CATEGORY OF BENEFICIARY	Code that indicates the patient's status from CATEGORY OF BENEFICIARY file
	ENTER THE ELIGIBILITY FOR THIS ADMISSION	For patients with dual eligibility, the eligibility associated with the admission
	MARITAL STATUS	Patient's marital status
	RACE	Patient's race
	SEX	Patient's sex
	DATE OF BIRTH	Patient's date of birth
	SPINAL CORD INJURY	Code that indicates if this patient sustained a spinal cord injury and, if so, what type

PTF Output Menu
Inquire PTF Record

Introduction

The Inquire PTF Record option is used to view the information contained in a patient's PTF records. The records are selected by patient name and, if there are multiple admissions for that patient, by admission. The user may select several different patients' records for viewing at one time through this option.

Information provided in the display may include marital status, race, date of birth, admitting eligibility, admission date, discharge date, discharge specialty, type of discharge, ASIH (absent-sick-in-hospital) days, PTF status, date of surgery, anesthesia technique, chief surgeon and surgical procedure (if any), pass days, source of pay, etc. The display will show the census status field if the patient needs a census record for the current census. PERIOD OF SERV field will appear as CAT OF BEN for discharges before 10-1-90.

Example

```
Select PTF PATIENT: CALVIN,THEODORE  03-17-46   339871234   NSC VETERAN
Admitted: 08-13-96  Transmitted
ANOTHER ONE: <RET>
DEVICE: HIMS PRINTER     RIGHT MARGIN: 80// <RET>
DO YOU WANT YOUR OUTPUT QUEUED? NO//  <RET>   (NO)
```



```
PTF RECORD                                   DEC 30, 1996 10:41 PAGE 1
PATIENT                 DISCHARGE DATE    ADMISSION DATE
SSN                        PTF #                  STATUS
-------------------------------------------------------------------------

CALVIN,THEODORE          NOV 28, 1996 13:48  AUG 13,1996  09:10
339871234                  47                        Transmitted
                                  Census Status: Transmitted


        Facility: 500                     Marit Stat: DIVORCED
  Source of Adm: SELF-WALKIN                    Race: BLACK
   Source of Pay:                                Sex: MALE
Trans Facility:                        Date of Birth: MAR 17, 1946
     Admit Elig: NSC                             SCI: NOT APPLICABLE
    Vietnam SRV: NO                            State: NEW YORK
            POW: NO                          Zip Code: 12307
        POW SRV:                              County: SCHENECTADY
     Ion Rad Exp: NO
    Agent Or Exp: NO
```

Quick Load/Edit PTF Data

Example

Example 1 - Non-VA PTF (Fee Basis) record

```
Select PTF PATIENT:  ROLLO,ANTHONY   12-17-50    101101101
     1                Admitted: 04-09-96 Open FEE BASIS
     2                Admitted: 02-27-97 Open
TYPE '^' TO STOP, OR
CHOOSE 1-2:  1

* editing 101 & 701 transactions
FACILITY: 500//  <RET>
SUFFIX:  <RET>
SOURCE OF ADMISSION: lP//  3C
SOURCE OF PAYMENT: CONTRACT-PUBLIC&PRIV//   <RET>
TRANSFERRING FACILITY:  <RET>
TRANSFERRING SUFFIX:  <RET>
THIS PATIENT HAS OTHER ENTITLED ELIGIBILITIES:
     NSC
     SHARING AGREEMENT
ENTER THE ELIGIBILITY FOR THIS ADMISSION: NSC//    <RET>
  MARITAL STATUS: NEVER MARRIED//  DIVORCED
  RACE: WHITE, NOT OF HISPANIC ORIGIN//   <RET>
  SEX: MALE//  <RET>
  DATE OF BIRTH: 1950//  <RET>
  SPINAL CORD INJURY: NOT APPLICABLE//   <RET>
  VIETNAM SERVICE INDICATED: NO//   <RET>
  RADIATION EXPOSURE INDICATED: NO//   <RET>
  POW STATUS INDICATED: NO//   <RET>
  STATE: NEW YORK//  <RET>
  ZIP+4: 12189//  <RET>
  COUNTY: 001//  <RET>
MEANS TEST INDICATOR: NOT APPLICABLE//   <RET>
DISCHARGE DATE: MAY 12,1996//  <RET>
DISCHARGE SPECIALTY: GASTROENTEROLOGY//  CARDIOLOGY
TYPE OF DISPOSITION: REGULAR//  <RET>
DISCHARGE STATUS: BED OCCUPANT//  <RET>
PLACE OF DISPOSITION: HALFWAY HOUSE//   RETURN TO COMMUNITY-INDEP
OUTPATIENT TREATMENT: YES//  NO
VA AUSPICES: YES//  NO
RECEIVING FACILITY:  <RET>
RECEIVING SUFFIX:  <RET>
C&P STATUS: COMP/SC COND >10%//  <RET>
ASIH DAYS:  <RET>
DXLS: 428.0//  428.1     LEFT HEART FAILURE
         ...OK? YES//  <RET>
PRINCIPAL DIAGNOSIS:  <RET>
ICD 2:  <RET>
ICD 3:  <RET>
ICD 4:  <RET>
ICD 5:  <RET>
```

Quick Load/Edit PTF Data

Example

Example 2 - VA PTF record

```
Select PTF PATIENT:  ROLLO,ANTHONY        12-17-50     101101101
     1                Admitted: 04-09-96 Open FEE BASIS
     2                Admitted: 02-27-97 Open
TYPE '^' TO STOP, OR
CHOOSE 1-2:  2

Updating PTF record #181
* editing 101 & 701 transactions
FACILITY: 500//  <RET>
SUFFIX:  <RET>
SOURCE OF ADMISSION: lP//   <RET>
SOURCE OF PAYMENT:  <RET>
TRANSFERRING FACILITY:  <RET>
TRANSFERRING SUFFIX:  <RET>
THIS PATIENT HAS OTHER ENTITLED ELIGIBILITIES:
     NSC
     SHARING AGREEMENT
ENTER THE ELIGIBILITY FOR THIS ADMISSION: NSC//    <RET>
  MARITAL STATUS: NEVER MARRIED//  DIVORCED
  RACE: WHITE, NOT OF HISPANIC ORIGIN//   <RET>
  SEX: MALE//  <RET>
  DATE OF BIRTH: 1950//  <RET>
  SPINAL CORD INJURY: NOT APPLICABLE//   <RET>
  VIETNAM SERVICE INDICATED: NO//   <RET>
  RADIATION EXPOSURE INDICATED: NO//   <RET>
  POW STATUS INDICATED: NO//   <RET>
  STATE: NEW YORK//  <RET>
  ZIP+4: 12189//  <RET>
  COUNTY: 001//  <RET>
PLACE OF DISPOSITION: COMMUNITY HOSPITAL//   RETURN TO COMMUNITY-IN
OUTPATIENT TREATMENT: YES//   ^
DXLS:  <RET>
ICD 2:  131.02    TRICHOMONAL URETHRITIS
           ...OK? YES//   <RET>
ICD 3:  <RET>
ICD 4:  <RET>
ICD 5:  <RET>
ICD 6:  <RET>
ICD 7:  <RET>
ICD 8:  <RET>
ICD 9:  <RET>
ICD 10:  <RET>
* editing 501 transactions
Select 501 MOVEMENT NUMBER:  2   02-28-97
  TREATED FOR SC CONDITION: NO//   <RET>
```

Quick Load/Edit PTF Data

Data Supplement

SCREEN	FIELD NAME/ TITLE OF PROMPT	DESCRIPTION
"101" & "701"	FACILITY	Facility number where patient was admitted.
	SUFFIX	Suffix of admitting facility
	SOURCE OF ADMISSION	Source of this patient admission; from SOURCE OF ADMISSION file
	SOURCE OF PAYMENT	For patients treated at non-VA hospitals at VA expense; from set of codes
	TRANSFERRING FACILITY	VA facility from which the patient was transferred
	TRANSFERRING SUFFIX	Suffix of transferring facility
	ENTER THE ELIGIBILITY FOR THIS ADMISSION	For patients with dual eligibility, the eligibility associated with the admission
	SPINAL CORD INJURY	Code which indicates if this patient sustained a spinal cord injury and, if so, what type
	DATE OF BIRTH	Patient's date of birth
	AGENT ORANGE EXPOS. INDICATED	Was patient exposed to Agent Orange? Yes/No/Unknown
	RADIATION EXPOSURE METHOD	How was patient exposed to radiation? Hiroshima-Nagasaki /Nuclear Testing/Both
	POW CONFINEMENT LOCATION	War in which patient was a prisoner of war
	MEANS TEST INDICATOR	Represents patient's Means Test status
	DISCHARGE SPECIALTY	Specialty from which patient was discharged
	ZIP+4	5 or 9 digit zip code

Load/Edit Patient Data

Introduction

The Load/Edit Patient Data option is used to enter, edit, and view information contained in a patient's record without making a registration entry in the Disposition Log or creating a 10/10 Form (Application for Care). You may also make HINQ inquiries and print patient data cards. New patient records may be entered into the system or the records of existing patients may be edited. You may wish to use it to enter new patients into your database for whom applicable information has been mailed to your facility for actual registration at a future date.

Entry/edit of a patient's record is done via a series of formatted data screens. There are a total of fifteen screens distributed with the MAS Package. Screens 12-14 are informational only. The enter/edit process will not be the same for every patient, nor for every user due to several variables which exist in the system. Your site has the ability to create its own additional screen in order to capture certain information it may need or to capture information in a different format. It has the ability to turn certain data screens ON and OFF according to Patient Type. Within the screens, it may specify which data groups may be entered/edited. The DG ELIGIBILITY security key also plays a role in your ability to enter/edit data. Depending upon whether eligibility has been verified, certain information may only be edited by a user holding this security key.

The HIGH INTENSITY field in the MAS Parameters has been provided to assist you in the identification of those fields which may/may not be edited. If this field has been set to YES at your facility, the number next to those data groups which may be edited will be in boldface type; those which are uneditable will not (excluding Screen 8). For those sites not using High Intensity, numbers of data groups which may be edited will be enclosed in [ ]s, while those which are uneditable will be enclosed in < >s (excluding Screen 8). The Supplement at the end of this section provides an example of each data screen and a description of each associated field. Please refer to this Supplement when entering or editing patient information.

If your site has the Consistency Checker function turned ON, the system will perform a check for inconsistent/unspecified data elements at the conclusion of the entry/edit process. If any inconsistent/unspecified data elements are found, you will be given the opportunity to make the necessary corrections.

Screen 8 of this option uses the List Manager utility. The List Manager is a tool designed to display a list of items. It allows you to select items from the list and perform specific actions against those items. The following is a brief explanation of some of the actions listed on this screen.

Means Test User Menu
Edit an Existing Means Test

Introduction

The Edit an Existing Means Test option is used to make changes to data in existing Means Tests. It may also be used to complete Means Tests on patients identified through Registration as requiring Means Testing. Only the latest Means Test may be edited. A Means Test that has been verified by the Income Verification Match (IVM) Center and its corresponding original VAMC Means Test are both uneditable. If you choose such a Means Test, the system will display a message containing this information. However, this option will let you view or print such a test.

The Edit an Existing Means Test option operates similarly to the Add a New Means Test and Complete a Required Means Test options; however, it is the only option which allows changes to completed Means Tests. After these changes are entered, the system redetermines the patient's Means Test category and changes it, if necessary. If additional information is needed to make a determination or if it is necessary to refer the case to adjudication, the system prompts accordingly.

The date(s) and name(s) of individual(s) making changes is recorded by the system and may be seen through the View Means Test Editing Activity option.

A Means Test is required under the following conditions.

- primary eligibility is NSC or 0% service-connected non-compensable
- does not receive disability retirement from the military
- is not eligible for Medicaid
- is not on a domiciliary ward
- has not been Means Tested in the past year

Should these criteria change (excluding the last two), a Means Test status of NO LONGER REQUIRED will be assigned to the Means Test. Tests with this status cannot be edited.

Depending on the information entered on Screen 1, Screen 2 may appear with one column - veteran; two columns - veteran/spouse; or three columns - veteran/spouse/dependents. The item number(s) you select for editing may be preceded by V (veteran), S (spouse), or C (children) to select those specific fields; otherwise, the fields for all three will be displayed.

Register a Patient

Introduction

The Register a Patient option is used to process a patient's application for care, enter/edit information in their file, and perform a variety of registration-related functions. Necessary registration data is gathered and a corresponding entry is automatically made in the Disposition Log. This entry must receive subsequent dispositioning through the Disposition an Application option or the registration should be deleted through the Delete a Registration option. A new patient's record may be established or an existing one edited. Should you wish to enter a new patient into the database or edit an existing patient's record without creating an entry in the Disposition Log, you should use the Load/Edit Patient Data option.

Entry/edit of a patient's record is done via a series of formatted data screens. There are a total of fifteen screens distributed with the PIMS package. Screens 12-14 are informational only. The enter/edit process will not be the same for every patient, nor for every user due to several variables which exist in the system. Your site has the ability to create its own additional screen in order to capture certain information it may need or to capture information in a different format. It has the ability to turn certain data screens ON and OFF according to patient type. Within the screens, it may specify which data groups may be entered/edited. The DG ELIGIBILITY security key also plays a role in your ability to enter/edit data. Depending upon whether eligibility has been verified, certain information may only be edited by a user holding this security key.

The HIGH INTENSITY field in the MAS parameters has been provided to assist you in the identification of those fields which may/may not be edited. If this field has been set to YES at your facility, the number next to those data groups which may be edited will be in boldface type; those which are uneditable will not (excluding Screen 8). For those sites not using High Intensity, numbers of data groups which may be edited will be enclosed in [ ]s, while those which are uneditable will be enclosed in < >s (excluding Screen 8).

The Supplement at the end of this section provides an example of each data screen and a description of each associated field. Please refer to this Supplement when entering or editing patient information, if necessary.

If your site has the Consistency Checker turned ON, the system will perform a check for inconsistent/unspecified data elements at the conclusion of the entry/edit process. If any are found, you will be given the opportunity to make the necessary corrections.

Register a Patient

Example

```
                    APPOINTMENT INFORMATION, <SCREEN 14>

STRAIT,GARY; 435-23-4132                                         SC VETERAN
==============================================================================
<1> Enrollment Clinics: NOT ACTIVELY ENROLLED IN ANY CLINICS AT THIS TIME

<2>     Pending Appts:  NO PENDING APPOINTMENTS ON FILE

<RET> to QUIT, ^N for screen N, or '^' to QUIT:   <RET>



                    SPONSOR DEMOGRAPHIC INFORMATION, <SCREEN 15>

STRAIT,GARY; 435-23-4132                                         SC VETERAN
==============================================================================
<1> Sponsor Information:

No Sponsor Information available.

   Primary Care Manager:                    Phone #:


<RET> to QUIT, 1 or ALL to EDIT, ^N for screen N, or '^' to QUIT:    <RET>

Checking data for consistency...

===> No inconsistencies found in 1 second...

Is the patient currently being followed in a clinic for the same
condition? N   (NO)

Is the patient to be examined in the medical center today? YES//   Y   (YES)

Registration  login date/time: NOW//  <RET>   (JAN 26, 1997@09:10)
TYPE OF BENEFIT APPLIED FOR:  3   OUTPATIENT MEDICAL
TYPE OF CARE APPLIED FOR:  5   ALL OTHER
REGISTRATION ELIGIBILITY CODE: SC LESS THAN 50%//   <RET>   3   3   VETERAN

Updating eligibility status for this registration...

SC% AT REGISTRATION: 30//  <RET>

  NEED RELATED TO AN ACCIDENT:  N   NO
  NEED RELATED TO OCCUPATION:  N   NO

  Net Annual Income Thresholds on JAN 26,1997:
     Num. Dependents:  0 (Self)      1       2       3       4
     Net Income:         12855   15345   16713   18081   19449
Medication Copayment Exemption Status: NON-EXEMPT
Patient's income is greater than Copay Income Threshold
Test date: JAN 26,1997
```

View Registration Data

Introduction

The View Registration Data option allows you to view the registration information contained in a patient's record. You will not be able to edit a patient's data using this option.

As with the entry/edit of this information, viewing is accomplished in a series of screens. There are fifteen screens distributed with the MAS package. Your site has the ability to create its own screen in order to collect certain needed data or capture data in a different format. You may turn certain data screens ON and OFF according to patient type. Within the screens, you may specify which data groups should be editable.

You may move from screen to screen either by entering <^#> to specify the screen number you wish to move to, <RET> to move to the next screen, <?> to access its HELP screen, or <^> to quit.

Example

```
Select PATIENT NAME:  STRAIT,GARY      05-09-52     435234132      NSC VETERAN



                      PATIENT DEMOGRAPHIC DATA, <SCREEN 1>
STRAIT,GARY; 435-23-4132                                             NSC VETERAN
================================================================================
<1>    Name: STRAIT,GARY                     SS: 435-23-4132  DOB: MAY 9,1952
<2>   Alias: NO ALIAS ON FILE FOR THIS APPLICANT
<3> Remarks: NO REMARKS ENTERED FOR THIS PATIENT
<4> Permanent Address:                  <5> Temporary Address:
            66 PARK LANE                        NO TEMPORARY ADDRESS
            TROY,NY 12180
     County: RENSSELAER (083)                County: NOT APPLICABLE
      Phone: 444-4444                         Phone: NOT APPLICABLE
     Office: 444-0909                        From/To: NOT APPLICABLE


<RET> to CONTINUE, ^N for screen N, or '^' to QUIT:    <RET>
```

Registration Supplement - Screen Formats

The collection of patient registration data is done via a series of formatted data screens. There are fifteen of these screens distributed with the Medical Administration Service (MAS) package. The first eleven are dedicated to gathering the patient's registration information. This information makes up the patient's "file" in your computer. Screens 12-14 are for information purposes only and the data contained on them is not editable. They provide past admission and application information as well as the patient's clinic enrollments and a listing of future appointments. Each screen also has an associated HELP screen which may be accessed by entering a <?> at the prompt which appears on each screen. Following is a list of the fifteen screens.

Screen #1	PATIENT DEMOGRAPHIC DATA
Screen #2	PATIENT DATA
Screen #3	EMERGENCY CONTACT DATA
Screen #4	APPLICANT/SPOUSE EMPLOYMENT DATA
Screen #5	INSURANCE DATA
Screen #6	MILITARY SERVICE DATA
Screen #7	ELIGIBILITY STATUS DATA
Screen #8	FAMILY DEMOGRAPHIC DATA
Screen #9	INCOME SCREENING DATA
Screen #10	INELIGIBLE/MISSING DATA
Screen #11	ELIGIBILITY VERIFICATION DATA
Screen #12	ADMISSION INFORMATION
Screen #13	APPLICATION INFORMATION
Screen #14	APPOINTMENT INFORMATION
Screen #15	SPONSOR DEMOGRAPHIC INFORMATION

The registration or load/editing process will vary from patient to patient and user to user. This is due to several factors: the patient type, your site parameters, whether certain data has been verified, and whether you hold the DG ELIGIBILITY security key.

For each new patient entered into the system, you will be prompted to enter a patient type. Patient types are distributed with the package. Patient type will determine (in part) which screens are presented during the registration process, as well as which data items on the screens will be available for entry/edit. Screens 1, 2, 4, 5, 7, 12, 13, 14, and 15 will always be presented. The presentation of Screens 3, 6, 8, 9, 10, and 11 will vary as your site has the ability to turn these screens OFF and ON according to patient type. This has been done to allow each site flexibility in the collection of their patient data. For example, a site may not wish to collect military service data for a collateral patient. The Military Service Data Screen would then be turned OFF for that patient type.

Your site is also able to set up an additional registration screen should it wish to capture certain data in a different format. The fields displayed on this screen must already exist in the system (PATIENT file (#2)) so the data prompts associated with such a screen would be familiar to you. This screen, if set up, will always appear at the end of the registration process.

Certain data such as an applicant's name, SSN, date of birth, eligibility, monetary benefits, and service record are subject to verification. The verification must be performed by a holder of the DG ELIGIBILITY security key. Up until the time of verification, any user will be able to enter/edit data pertaining to these categories. After verification, the data may be viewed by all users; however, only those who hold the DG ELIGIBILITY security key will be able to edit this data.

Registration Supplement - Screen Formats

```
                   APPOINTMENT INFORMATION  SCREEN <14>
PATIENT NAME; SSN                                              TYPE
==================================================================
<1> Enrollment Clinics:

<2>     Pending Appts:

<RET> to QUIT, ^N for screen N, or '^' to QUIT:
```

This screen displays each clinic in which the patient is actively enrolled and the clinic name and date/time of all pending appointments.

If the applicant is not actively enrolled in any clinics or has no pending appointments, one of the following messages will be displayed next to the appropriate data group:

"NOT ACTIVELY ENROLLED IN ANY CLINICS AT THIS TIME"

"NO PENDING APPOINTMENTS ON FILE"

```
                SPONSOR DEMOGRAPHIC INFORMATION  SCREEN <15>
PATIENT NAME; SSN                                              TYPE
==================================================================
[1]     Sponsor Information:


     Primary Care Manager:                 Phone #:

<RET> to QUIT, 1 or ALL to EDIT, ^N for Screen N, or '^' to QUIT:
```

This screen displays sponsor information. It will appear for every patient although the purpose of the screen is to enter sponsorship information for those patients who are being treated under the coverage of someone else (the sponsor). This would usually be through the Tricare Program or CHAMPVA Program. These patients are usually dependents of active duty military personnel, survivors of military personnel, or military retirees.

If a sponsor is already in the PATIENT file (#2), you may not edit the sponsor name and date of birth. For new sponsors, you will be prompted to first add the person as a sponsor and then as the sponsor of the patient. For existing sponsors, you will only be asked if you wish to make that person the sponsor of the patient.

The primary care manager and phone# data elements are not entered through this screen. If available, this information is automatically filled in from the Primary Care Management Module of the Scheduling software. This is the name and phone number of the patient's primary care provider.

Registration Supplement - Screen Formats

SCREEN 15, cont.

DATA GROUP 1

Select SPONSOR - Enter the name of the person who has the coverage under which the patient will be treated. This is a multiple field; you will be returned to this field repeatedly until no more sponsors are entered. (A patient may have more than one sponsor; e.g., both parents are military retirees.) The first two indented fields will only be prompted for if the sponsor is a non-patient (not in the PATIENT file (#2)).

> SPONSOR PERSON DATE OF BIRTH - Enter the sponsor's date of birth.
>
> SPONSOR PERSON SOCIAL SECURITY NUMBER - Enter the sponsor's SSN.
>
> MILITARY STATUS - Choose A (Active Duty) **or** R (Retired).
>
> BRANCH - Enter the branch of service for the sponsor. You may enter a <?> for a current list of choices.
>
> RANK - Enter the military rank of the sponsor (3-20 characters).

FAMILY PREFIX - The patient's relationship to the sponsor. This is a free text field; however, it is recommended you use the DOD convention for sponsor relationship codes. You may enter <??> for HELP which contains a list of choices.

SPONSOR TYPE - Choose T (TRICARE) **or** C (CHAMPVA).

EFFECTIVE DATE - Effective date of sponsorship.

EXPIRATION DATE - Expiration date of sponsorship.